Improving Identification of the Religious Affiliations of Hospital Inpatients

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This article focuses on best practices for identifying religious affiliations (RA) of inpatients efficiently and integrating the interdisciplinary team in the problem solving and performance improvement implementation. It highlights one such project at Abington (PA) Memorial Hospital that utilized the GE Lean performance improvement methodology and details the positive outcomes realized. A flowchart detailing implementation of the process is included.

IDENTIFYING A PATIENT’S RELIGIOUS AFFILIATION (RA)

in an accurate and timely manner has long been considered an essential part of spiritual assessment and pastoral care. However, in many clinical settings this task may be a complicated endeavor as obtaining this information about a patient’s belief system and affiliation often involves multiple disciplines and multiple information systems interfaces.

Rationale

Effectively addressing emotional needs, which includes meeting spiritual needs and support from one’s religious community, is consistently among the top five priorities listed by patients and their families according to data collected by Press Ganey and other patient satisfaction organizations. Further, “while the Joint Commission leaves the specifics to each organization, spiritual assessment should, at a minimum, determine the patient’s religious affiliation (if any), as well as any beliefs or spiritual practices that are important to the patient.” As a result, this also is vitally important to us as professional chaplains. Performance improvement methodologies, such as GE Lean are excellent tools for raising organizational awareness, engaging interdisciplinary and administrative collaboration with professional chaplains as members of the health care team. Striving to continuously improve the accuracy and collection of RA data is one way that chaplains participate in achieving positive outcomes for patients and their families.

Background

Prior to 2008, RA identification was obtained from fewer than 50 percent of all inpatients at Abington Memorial Hospital (AMH). These results were unacceptably low, and none of the following efforts had yielded lasting improvement:

- Meeting with leaders from the admissions department, through whom an initial inquiry regarding RA is made.
- Meeting with nursing and informatics leaders to seek to improve the documentation template in which nurses are also tasked with inquiring about RA as part of the patient profile interview.
- Meeting with leaders from the financial systems department, who oversee the computer system through which RA data is recorded and reported.
• Providing inservices both to educate and to remind staff of the importance of accurate identification of RA.

In 2006, AMH implemented the Sunrise Clinical Manager (SCM) and Knowledge-Based Charting (KBC) systems by Eclipsys as added layers in the electronic medical record (EMR) data entry systems. These were interfaced with the existing Technicon Data Systems (TDS), a patient registration information system, which also included order entry, results reporting and ancillary documentation.

SCM includes a patient profile, which the nurse is required to complete within twenty-four hours of a patient’s arrival on the clinical unit. Two brief screening RA questions are asked as part of this interview:

• Do you have any spiritual, religious issues/concerns?
• Do you consent to having your name appear on the spiritual care visitation listing?

An affirmative answer to the first question automatically triggers a referral to pastoral care, and a clinically trained, staff chaplain completes a more detailed spiritual assessment utilizing the FICA model (Faith, Importance, Community, Address) as well as the outcomes-based KBC documentation system.

Despite this procedure, there still were significant gaps in how RA data were collected and collated. While RA data entered in the TDS system automatically migrated to the SCM system, the reverse was not the case. Thus, TDS files had to be updated manually by pastoral care staff to conform to SCM. Complicating the situation, TDS generated the religious census as well as the lists provided to local clergy and volunteers making pastoral care visits.

In May 2008, AMH instituted an organization-wide performance improvement initiative. Staff in each department were tasked with developing at least one performance improvement “Work Out” utilizing the GE Lean methodology. The gap in accurate identification of RA of hospital inpatients was selected as a pastoral care quality improvement project for the initiative.

The process

The GE Lean Work Out process is described as a process of concentrated, team-based decision making and empowerment used to resolve issues and improve processes. The Work Out event itself is a highly structured, facilitated meeting to allow the team of experienced, knowledgeable people with a stake in the issue to develop solutions and action plans.³

Roles within the Work Out include the following:

• **Sponsor** – brings issue, identifies key participants, secures VP approval, records action items and is responsible for follow-up and reporting on action items.

• **Champion** – provides focus and strategic direction, assigns resources and defines organizational accountability. Often a member of the administration fills this role.

• **Change agent** – partners with sponsor to prep for workout, facilitates and leads Work Out session.

• **Work Out participants** – represent stakeholders and departments involved in issue and assure ownership of specific action plans within their departments.

These key participants are gathered together in a daylong, closed-door meeting to identify the various aspects of a given problem and to craft a detailed, comprehensive solution including action plans for each department.
The problem was first examined generally beginning with the huge deficiency in RA data collection and possible factors contributing to this discrepancy. For many years, RA data had been recorded as part of the admissions process. Within the TDS system, seventeen possible RAs were available for the registrar to select. In 2010, it was replaced by the more functional STAR Navigator system, by McKesson.

Drafting the plan

Obstacles to effective RA data collection were identified:

- Difficulty in ascertaining RA from a significant portion of inpatients who were admitted through the emergency room (ER) or were unresponsive.
- Inconsistent phrasing of the inquiry.
- Unclear impression given to patients regarding how the information would be used.
- Restrictions imposed by the Health Insurance Portability and Accountability Act (HIPAA) regulations.

The GE Lean Work Out interdisciplinary team proposed the following to address these obstacles:

- Modify the scripting and process by which RA data are asked for and recorded in the registration information system by the admissions department.
- Streamline the spiritual and religious needs questions on the nursing patient database part of the KBC evidence based documentation system.
- Edit RA categories to obtain more accurate data.
- Provide ongoing staff education regarding vital importance of asking and accurately recording RA.
- Enlist pastoral care volunteers as another tier of data collection.
- Task staff chaplains with following up with all patients whose RA is listed as “other” or “unobtainable.”

A detailed process flowchart was constructed, tracing each layer of data collection. It also detailed how and where the data were reported and utilized to identify and address the religious and spiritual (R/S) needs of inpatients. (See Attachment A.)

Implementing the plan

During the Work Out, we discovered that the category “unknown” had become a catchall for patients whenever data were collected, usually because the question was not asked due to an unresponsive patient and/or admission through ER. In January 2009, two more descriptive categories were added: “unobtainable” and “no religious preference.” This also reinforced the expectation that an inquiry would be made of all patients within twenty-four hours of hospital admission.

In March 2009, a comprehensive and in-depth round of staff education was implemented hospital-wide, which included the following:

- Admission staff were provided with a revised, clearer, more streamlined script for inquiring about RA and educated in its use.
• Nursing staff were reminded of the importance of inquiring about RA and spiritual needs during the patient profile interview. Articles and announcements were published in staff newsletters throughout the hospital.

• Staff chaplains were tasked with actively inquiring about RA with patients on their assigned units whenever the affiliation was listed as “unobtainable” or “other.”

• Pastoral care volunteers were trained and provided brief, scripted RA questions to use during initial visits with recently admitted inpatients. More than a year’s worth of detailed statistical data collection from these visits substantiates their significant contribution.

**Tracking our progress**

As a result of streamlining the process by which data are collected, there was significant improvement in the percent of patients’ RAs accurately identified. All involved disciplines participated in improving accuracy and decreasing the time within which RA was recorded, referrals made and needs addressed.

R/S needs now may be identified and accommodated much earlier in the hospital stay, resulting in more efficient and timely provision of sacramental and faith-specific visitation. RA data, including whether visitation is desired, are communicated through the EMR with an evidence-based model and shared, as appropriate, at case conferences. Identifying R/S needs early in the admission has resulted in improved efficiencies in the use of chaplaincy staff time. Previously, pastoral care services often were not requested until an emergency arose or just prior to discharge.

Improved community clergy identification of congregants on the hospital’s religious census who desire visitation, while maintaining full HIPAA compliance also has resulted. A significant reduction in the number of last-minute requests for faith-specific services has been observed by pastoral care staff; however, this factor is difficult to quantify. One option for assessing this aspect of care is to conduct periodic reviews of patient satisfaction comments.

In June 2009, immediately following completion of training, publicity and verbal reinforcement at unit meetings, and with all disciplines actively engaged and intently focused on the goal, the RA percentage spiked to 88 percent. Although it dropped the following month, the steady upward trend continued beyond the March 2010 project completion date. As of August 2010, RA compliance surpassed 80 percent, a 30 percent improvement over the 2008 baseline.

Details were included in a poster presentation by the author at the 2010 APC Annual Conference. This document and extensive statistical data collected throughout the course of the project are available on request.

**Further steps**

AMH has now phased out the TDS information systems program, replacing it with the STAR Navigator interface from McKesson. This significantly improves the options available for RA recording and makes it easier to accurately record affiliations that previously would have been lumped into the general category of “other.”

Nevertheless, we face several new challenges:

• A very limited number of computer terminals provide access to the STAR McKesson interface, ostensibly due to the highly sensitive nature of admissions data collected within the program.

• It is necessary to log into an application separate from the SCM program; previously a TDS tab provided access with only one log-in.
• RA and spiritual assessment data are collected by admissions staff, nurses, chaplains and
other disciplines in at least four separate locations within the EMR. STAR is used by
admissions, KBC by nursing for both adult and pediatric patient profiles and yet another
system by maternity/labor and delivery nursing staff. To add to the challenge, not all these
systems interface with one another.

The maternity and neonatal patient population has continually recorded the overall lowest
percentage of RA, generally below 40 percent.

Nursing leadership in the maternity and neonatal units has been working closely with pastoral care
on strategies to improve compliance within this area. Strategies presently being pursued include
providing additional staff education and raising awareness through presentations at unit councils
and interdisciplinary rounds as well as articles in newsletters and other staff communications. In
addition, access to the system used by maternity/labor and delivery would allow tracking and
updating of RA data, including transfer into the hospital-wide STAR McKesson system database as
necessary.

This project presents one model for dramatically improving effectiveness in the collection of RA
data among hospital inpatients utilizing the GE Lean Work Out process. As the results clearly show,
significant improvement is possible when a comprehensive interdisciplinary team establishes clearly
outlined goals and a mutually determined plan for achieving the desired results.

1 George Fitchett, Spiritual Assessment in Pastoral Care (Decatur, GA: Journal of Pastoral Care Publications, 1993), 1; Paul
and Health (New York: MacMillan Press, 1947); Carroll A. Wise, Religion in Illness and Health (New York: Harper Press,
1942).


Attachment A: Flow chart – Religious affiliation (RA) performance improvement project at Abington (PA) Memorial Hospital utilizing GE Lean Work Out

Religious affiliation (RA) identification remained under 50% despite previous improvement efforts.

GE Lean process improvement model utilized to address gap with comprehensive, interdisciplinary collaborative approach.

GE Lean Work Out, held in November 2008, included all involved disciplines and key roles.

Pastoral Care
- Awareness of RA importance raised through newsletter and in-services with staff.
- Staff chaplains tasked with RA inquiry of patients listing “other” or “unobtainable.”
- Pastoral care volunteers tasked with RA inquiry of all patients without RA listed.

Nursing
- Added RA inquiry to mandatory fields in patient profile.
- Patient profile to be completed within 24 hours of arrival.

Administration
- Endorsed GE Lean process improvement model, mandated participation and implementation throughout organization.

Health Info
- Modified phrasing of RA questions based on work out recommendations.
- Changed RA category “unknown” to “unobtainable.”

Admissions
- RA inquiry to be made of all patients upon admission.
- Scripting of RA inquiry revised to enhance patient understanding of how information is used and to assure consistency.

RA compliance surpassed 80% in August 2010, an increase of 30%.